Union County College – Respiratory Care Program – Student Health Form

NOTE: All areas must be completed

Name: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Personal Health Overview (completed by student):

Identify any current health problems:

_____

Medications taken:

_____

Known Allergies:

_____

Physical Examination (completed by Licensed Physician or Nurse Practitioner):

Physical examination completed (Date): _____

Limitation in physical activity? ☐ Yes ☐ No

If yes, please explain: _____

_____

The student is able to participate in clinical patient care activities without restrictions: ☐ Yes ☐ No

If no, please explain specific restrictions: _____

_____

_____

Laboratory:

Laboratory Test	Date	Within Normal Limits
CBC	_____	☐ Yes ☐ No
Urinalysis	_____	☐ Yes ☐ No
Blood Chemistry/Metabolic Panel	_____	☐ Yes ☐ No

****Any abnormalities found require documentation by the provider and approval to participate in the program indicated. A positive drug screening may interfere with your ability to go to the clinical sites.***

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Immunizations:

Blood titer levels need to be completed! Receipt of vaccine or history of the disease does not demonstrate immunity status. After any vaccines are received, a follow-up blood titer may be done to determine immunity. Actual blood values and immunity status for each titer must be entered by the healthcare provider.

Vaccine	Date Received	Immunity Status	Follow-up Titers	Blood Values
Measles	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Mumps	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Rubella	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Varicella	_____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
Hepatitis B	1st dose _____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
	2nd dose _____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____
	3rd dose _____	Immune ☐ Yes ☐ No	Immune ☐ Yes ☐ No	_____

Hepatitis C: ☐ Positive ☐ Negative

Vaccine	**Date Received**
Flu Vaccine (Annual Requirement)	_____
Tetanus, Diphtheria, Pertussis Vaccine*	_____

*Receipt of vaccine must be within 2 years of the date on this form

Urine Drug Screening with confirmation Date: _____ ☐Positive ☐ Negative

Note: **If vaccines are declined, signed copies must accompany this form. Students who are not immune to the infectious diseases noted may be prohibited by the clinical agencies from participating in clinical experiences in areas where disease transmission poses a high risk to patients, staff, visitors and or students.**

Two-Step Mantoux Test**

Mantoux testing, chest x-ray or pulmonary clearance is required on an annual basis.

Test	Date	Results
Two-Step Mantoux	_____	☐ Positive ☐ Negative
Chest X-Ray	_____	Results: _____
		Medication: _____
Pulmonary Clearance (attach forms)	_____	

** A two-step Mantoux is not required if documentation is provided of a negative Mantoux within 12 months of the date noted by the healthcare provider. Students who have positive Mantoux tests or who are not able to take the Mantoux (prior receipt of BCG) are required to have chest x-rays or pulmonary clearance from the healthcare provider

_____

Examiner's Name, Credentials, License #, Address (Official Stamp **REQUIRED)**

_____

Examiner's Signature **(REQUIRED)**

_____

Date